

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-018162

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

FILED MAY 9 1963

Primary Registration District No.

1003

Registrar's No.

4869

1. PLACE OF DEATH a. COUNTY - - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY - - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in lb 6 weeks	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Anthony's Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. STREET ADDRESS 6331 Alabama		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First Middle Last CECIL DANIEL RYAN		4. DATE OF DEATH Month Day Year May 3 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1902	9. AGE (last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (City and state or country) St. Louis, Missouri	
12. CITIZEN OF WHAT COUNTRY U. S. A.					

13a. FATHER'S NAME James Michael Ryan		13b. MOTHER'S MAIDEN NAME Elizabeth Mc Carthy		14. NAME OF HUSBAND OR WIFE Lillie Ryan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Lillie Ryan, 6331 Alabama	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hemorrhagic pancreatitis		INTERVAL BETWEEN ONSET AND DEATH 2 plus	
DUE TO (b) due to an embolus		2 plus	
DUE TO (c) Arterio sclerotic heart disease		5 years	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4200		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
--	--	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from March 25, 1963 to May 3, 1963 and last saw him alive on 5-3-63 Death occurred at 3 PM on 5/3/63 m on the site stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) Joseph E. von Kaenel M.D.		22b. ADDRESS 634 N. Grand Blvd.		22c. DATE SIGNED 5/4/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-6-63	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cemetery		23d. LOCATION (City, town, or county) St. Louis County, Missouri	

24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY		ADDRESS 6464 Chippewa St. Louis Mo.		25. DATE RECD. BY LOCAL REG. MAY 6 1963	
26. REGISTRAR'S SIGNATURE Loan Smith. M.D.					

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
1
2
3
4
5
6
7
8
9
10
11
12
13

73

Dr. J. E. VonKanel
Mo. Theater Bldg.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John L. Denny

Licensed Embalmer No.

4194

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

• If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

• If this body is not embalmed, fact should be so stated above.